Maine HIV/ AIDS 1115 Demonstration

Operational Protocol

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[1] The organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. The State will also include in this section a discussion of the content and frequency of reporting items as listed in **Attachments A** and **C** of this document.

The following Organizational and Structural Administration exists at the Bureau of Medical Services to implement, monitor and operate the Maine HIV/AIDS 1115 Demonstration, and will be adapted for use by the HIV Waiver benefit. The following is from the Bureau's *MaineCare Benefits Manual* (MCBM).[1]

The administrative structure that will be used to manage the HIV Waiver benefit is comprised of the following organizational components of the Maine Department of Human Services: Bureau of Medical Services, Bureau of Family Independence and the Bureau of Health. Each entity will be responsible for certain functions related to implementing, monitoring and operating the Demonstration.

The Bureau of Medical Services (BMS) is responsible for the administration of MaineCare and Healthy Maine Prescriptions. Responsibility for the management of these programs falls across five divisions: Program Evaluations, Quality Improvement, Finance and Reimbursement Services, Policy and Provider Services, and Licensing and Certification. Further support comes from a BMS Deputy Director, Assistant Director, Medical Director, and Pharmacy Consultant. The five BMS divisions have the responsibility of assuring the timeliness and integration of the joint demonstration effort within the larger HIV benefit implementation (e.g., rule-making, evaluation design, etc.). In addition, they will facilitate HIV Waiver benefits with standard Medicaid-funded HIV/AIDS case management services.

- The Division of Program Evaluation is responsible for the information system and analysis needs of the Bureau. The Director of this Division is responsible for designing, planning, installing and supporting all of the Bureau's information systems. This division, in conjunction with the Department of Technical Services, will have responsibility for implementing the systems modifications necessary to successfully process claims for the HIV Waiver.

- The Division of Quality Improvement is responsible for monitoring provider and recipient compliance with MaineCare program policies and regulations, developing quality improvement standards, and evaluating the quality of recipient care. The Division of Quality Improvement will be responsible for monitoring quality and will take the lead on implementing the research design for the HIV Waiver. The Director will coordinate these efforts with the Bureau's Medical Director, Pharmacy Consultant and the Pharmacists within the Division.

- The Division of Finance and Reimbursement Services has responsibility for acute and long-term care financing, the certificate of need program, claims management, and third party liability and recovery. This division will be responsible for tracking and analyzing all financial and cost-

[1] Relevant information on the MaineCare Benefits Manual, Chapter 1 appears as **Attachment I**.

related data and providing appropriate reports to CMS in accordance with the Financial Requirements listed below.

- The Division of Policy and Provider Services is responsible for developing and explaining MaineCare policies. This Division will develop the regulations governing the Demonstration program. Policy and Provider Services also provides information, education and assistance to both providers and has responsibility for responding to providers' inquiries regarding client eligibility, status of claims and resolution of billing issues. As such, this Division will assist in the on-going education of providers and resolution of day-to-day provider inquiries related to the HIV Waiver.

- The Division of Licensing and Certification is responsible for the State licensing of health care facilities and agencies; it will not have a direct role in this project.

The Bureau of Family Independence (BFI) has the responsibility of accepting applications for enrollment in the HIV Waiver benefit, and determining financial eligibility. BFI will send notices to clients and the Bureau of Health (BOH) regarding the decision of financial eligibility or ineligibility. When an enrollee is required to pay a premium, BFI will include this information. Financial eligibility for the HIV Waiver benefit will be reviewed by BFI every twelve months. BFI will represent the Department in fair hearings concerning issues of financial eligibility.

The Bureau of Health (BOH) is responsible for determining whether medical criteria for the HIV Waiver are met, and informing BFI of the results of this determination. If the client is found not to be medically eligible BOH will directly inform the client and BFI of the decision, and the reason for the decision. In addition, BOH will oversee benefit integration with AIDS Drug Assistance Program (ADAP) and HIV prevention services. BOH will also be responsible for maintenance of the waiting list, if needed.

The BOH has the responsibility of assuring overall integration with RYAN WHITE Title II funded case management services.

Organizational and Structural Administration

The same administrative structure will be used to administer the HIV Waiver benefit as is used to administer the rest of the MaineCare program. This structure is described in Chapter 1 of the MaineCare Benefits Manual (**Attachment I**). In addition, Waiver benefit providers and members will be subject to the administrative requirements, rights, and responsibilities outlined in that chapter.

General Financial Requirements

Financial Reporting

The budget neutrality agreement under this demonstration requires the state to capture and report financial expenditures in accordance with the special terms and conditions for 1)individuals enrolled in the demonstration (demonstration enrollee) and 2)those individuals that are Medicaid eligible and HIV positive or Medicaid eligible and HIV positive from tracking algorithm developed by the State. This section of the operational protocol describes the policies and procedures that are necessary to implement the financial reporting requirements in Attachment A of the Special Terms and Conditions.

Maine will modify its Medical Management Information System (MMIS)State Transaction Accounting Reporting System (STARS) in order to facilitate expanded expenditure and budget reporting to CMS for the following reporting objectives:

- Reporting/claiming Federal Financial Participation (FFP);
- Tracking against the 1-year expenditure targets and the 5-year FFP cap;
- Estimating/Budgeting;
- Distinguishing expenditures separately for the individuals enrolled in the demonstration and for the Medicaid eligibles and HIV positive or Medicaid eligibles and HIV positive from tracking algorithm developed by the State; and
- Distinguishing expenditures by date of service to report expenditures in the correct demonstration year.

Expenditures will be reported according to the budget neutrality agreement year in which services were rendered or for which capitation payments were made. This will mean that fee for service payments (including reinsurance payments) will be reported according to date of service and capitation payments will be reported for the period for which the payment was made. This will mean that prior period capitation payments will not be reported in the month of payment, but rather in the period that the payment is intended to compensate the health plan for services.

As discussed below, member months reported are to include all prospective member months and fee for service enrollment converted into member months. Prior period capitation member months are not to be reported.

The Medicaid and State Children's Health Insurance Program Budget and Expenditure System - (MBES/CBES)

All claims related to the budget neutrality agreement will be reported on the State's quarterly CMS-64 expenditure report via the MBES/CBES. After entering this system, the State will access the appropriate forms by selecting the CMS-64 button on the left side of the screen. The State will click-on add/modify, then select the appropriate waiver reporting form from the drop down menu provided at the bottom of the screen. This drop down menu will provide access to the reporting Forms CMS-64.9 WAIVER, CMS-64.9P WAIVER, CMS-64.10 WAIVER, and CMS-64.10P WAIVER. These forms add directly into the CMS-64 Summary Sheet. This insures that the State will receive Federal match for all title XIX waiver expenditures. Once the appropriate form has been selected and entered, the State will either click-on the "add" bar to add a new waiver sheet or the "modify" bar to modify a waiver sheet that has already been entered into the system. Once this selection has been made, the next screen will provide a chart of all waivers for Maine. The chart provides information for each waiver by Waiver Type, Waiver Number, and Waiver Name. The waiver type column includes 1115, 1915(b), and 1915(c) waivers. The next column provides the waiver number. For 1115 waiver numbers, a block is included that needs to be completed with the correct demonstration year (i.e., -01, -02, -03, etc.). The demonstration year entered into the system will be the demonstration year in which services were rendered or for which capitation payments were made. Lastly, the list is grouped by waiver name. The waiver name consists of those eligibility groups or reporting categories identified in the Special Terms and Conditions and/or Operational Protocol. The eligibility groups for this demonstration will be identified as 1) ***demonstration enrollee*** for individuals enrolled in the demonstration or 2) ***HIV Positive by Algorithm*** for individuals that are Medicaid eligible and HIV positive profile which is a result of its quarterly run of the tracking algorithm. A separate CMS-64.9 WAIVER and/or CMS-64.9P WAIVER will be completed for each eligibility group covered under the budget neutrality agreement.

All capitation payments will be reported on line 18.A. of the Forms CMS-64.9 WAIVER and CMS-64.9P WAIVER. All fee-for-service (FFS) expenditures will be reported on the appropriate service line on the Forms CMS-64.9 WAIVER and CMS-64.9P WAIVER.

In order to achieve the necessary expenditure tracking by demonstration year, the last two digits of the "WAIVER NUMBER" data entry field will be extremely critical. The demonstration year is included as a part of the "WAIVER NUMBER" and is identified as a part of the extension. For example, Maine waiver number is 11W00128/ with the extension of 1-xx. The 1 represents the Boston Region and the xx represents the demonstration year.

> EX: Assume the implementation date was April 1, 1999. Expenditures reported for the quarter ended March 31, 20XX will be broken out by date of service and assigned to the correct demonstration year (/1-0X (current year) or /1-0X-1, etc.) on the current quarter expenditure report (03/31/XX). Capitation payments made in that same quarter (March 31, 20XX) for services covered in April 20XX will be claimed on the current quarter expenditure report (March 31, 20XX), but will be assigned to the next demonstration year (/2-0X+1).

Tracking of expenditures against the annual expenditure targets and the 5-year cap will begin July 1, 2002. The "first demonstration year" for budget neutrality purposes will be defined as extending from July 1, 2002 through June 30, 2003. For expenditures being claimed for dates of service beginning July 1 of each succeeding demonstration year, replace the last two digits with -02 through -05, respectively. In this way, Maine and CMS will be able to track the 1115 demonstration expenditures to the correct year of the expenditure target/cap. The expenditures for each demonstration year will be automatically accumulated on the CMS-64 Waiver Expenditure Report - Schedule C. The State will access this report on a quarterly basis to monitor its expenditures under the budget neutrality cap.

All offsetting adjustments attributable to the budget neutrality agreement that would normally be reported on lines 9 or 10.C. of any CMS-64 will be reported on line l0.B. The MBES/CBES system does not allow for these adjustments to affect waiver expenditures. Therefore, in order for these adjustments to be credited to the State's 1115 waiver expenditures, these offsets must be reported on line 10.B. and identified with the correct waiver information. This will allow these claims to be included in the CMS-64 Waiver Reports (Schedules A, B, and C) that the State will access and use as a tracking mechanism. Waiver Schedule A will provide waiver expenditures claimed for the current quarter. Waiver Schedule B will provide a cumulative total for previous waiver expenditures as reported, current quarter expenditures, and the total expenditures to date. Waiver Schedule C provides a breakout of waiver expenditures to date by WAIVER NAME, by demonstration year, and totals for both Total Computable (TC) and Federal Share (FS). For any other cost settlements (i.e., those not attributable to the budget neutrality agreement), the adjustments will be reported on lines 9 and 10.C., as instructed in the State Medicaid Manual.

In accordance with the Terms and Conditions Document of the Maine HIV/AIDS 1115 Demonstration:

1. The State of Maine will provide quarterly expenditures reports using the Form CMS-64 to report total expenditures for services provided under the MaineCare program, including those provided through the HIV/AIDS Demonstration under section 1115 authority.

    a. The State will report HIV/AIDS Demonstration expenditures through the Medicaid Budget and Expenditure System (MBES) as part of the routine CMS-64 reporting process to track

expenditures under this Demonstration. Expenditures subject to the budget neutrality cap will be reported on separate CMS-64.9 forms, and identified by the Demonstration project number assigned by the Center for Medicare and Medicaid Service (CMS).

b. For each Demonstration year, two separate CMS-64.9 forms will be submitted to report expenditures subject to the budget neutrality cap. On the first, expenditures for members enrolled in the Demonstration will be reported; on the second, expenditures identified for HIV positive members identified from existing and future HIV positive MaineCare members by the algorithm (run at the beginning of the Demonstration and quarterly thereafter) will be recorded.

c. The State will track the expenditures and numbers of demonstration and MaineCare members using the algorithm it used to identify HIV positive individuals currently enrolled in MaineCare. In addition to using this algorithm for the purpose of CMS-64.9 reports, the algorithm will be run quarterly and numeric counts submitted with the respective quarterly progress reports.

d. The State will separately track and report administrative costs related to claims processing, marketing, and the utilization of outside contractors that are attributable to the Demonstration.

e. The State will make all claims for expenditures subject to the budget neutrality cap within 2 years of the calendar quarter in which the State made the expenditures. Furthermore, the State will make all claims for services during the Demonstration period (including any cost settlements) within 2 years of the conclusion or termination of the Demonstration. During the latter 2 year period, the state will continue to separately identify net expenditures related to dates of service during the operation of the 1115 Demonstration on the CMS-64 form in order to properly account for these expenditures in determining budget neutrality.

3. Maine will estimate matchable MaineCare expenditures on the quarterly CMS-37 form. As a supplement to the form, the State will provide updated estimates of expenditures subject to the budget neutrality cap.

4. Within 30 days of the end of each quarter the State will submit the CMS-64 form quarterly Medicaid expenditure report showing MaineCare expenditures made in the recently closed quarter.

5. Maine will certify State/ local moneys used as matching funds for the Demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

Other Financial Reporting Requirements

The following section details how the State will comply with all financial reporting requirements:

1. The State will provide quarterly expenditure reports using the CMS-64 form to report total expenditures for services provided under the MaineCare program, including those provided through the Maine HIV 1115 Waiver Demonstration under section 1115 authority. CMS will provide Federal Financial Participation (FFP) for allowable Demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment D of CMS Terms and Conditions for the Maine HIV 1115 Waiver (Monitoring Budget Neutrality).

2. a. In order to track expenditures under this Demonstration, the State will report Maine HIV 1115 Waiver expenditures through the Medicaid Budget and Expenditure System (MBES) following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. Applicable rebates and expenditures subject to the budget neutrality cap will be reported on

separate CMS-64.9WAIV forms and/or 64.9WAIV.P, identified by the CMS-assigned Demonstration project number (including the project number extension), which indicates the Demonstration year in which services were rendered.

For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this Demonstration) the adjustments should be reported on lines 9 or 10.c as instructed in the State Medicaid Manual. The term "expenditures subject to the budget neutrality cap" is defined below in item 2.c. Under present MaineCare regulations, there are no cost settlement amounts for this provider type, as it is not audited/cost settled.

b. For each Demonstration year, two separate CMS 64.9WAIV forms and/or 64.9WAIV.P (for prior period adjustments) will be submitted to report expenditures subject to the budget neutrality cap. On the first form, expenditures for members enrolled in the demonstration will be reported. On the second form, the expenditures identified for the current and future HIV positive MaineCare members (identified by the algorithm at the beginning of the Demonstration and quarterly thereafter) will be recorded. The sum of these sheets, for all Demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap.

c. For the purpose of the section, the term "expenditures subject to the budget neutrality cap" will include all MaineCare expenditures on behalf of individuals who are 1.) enrolled in the Demonstration; or, 2.) in the HIV positive cohort identified from existing MaineCare members by the algorithm at the beginning of the Demonstration, or 3.) are HIV positive and become eligible for full MaineCare benefits (identified by the algorithm that will be run quarterly). All expenditures that are subject to the limit by the expenditure ceiling are considered Demonstration expenditures and shall be reported on CMS 64.9WAIV form and/or 64.9WAIV.P.

d. Administrative costs will not be included in the budget neutrality limit, but the State will separately track and report additional administrative costs related to claims processing, marketing, and the utilization of outside contractors that are attributable to the Demonstration. Administrative costs related to claims processing, marketing, and the utilization of outside contractors will be tracked and reported on the CMS 64.10WAIV and/or 64.10WAIV.P.

e. All claims for expenditures subject to the budget neutrality cap (including any costs settlements) will be made within 2 years of the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) will be made within 2 years of the conclusion or termination of the Demonstration. During the latter 2-year period, the State will continue to identify separately net expenditures related to dates of service during the operation of the 1115 Demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

3. The standard MaineCare funding process will be used during the Demonstration. Maine must estimate matchable MaineCare expenditures on the quarterly CMS-37 form. As a supplement to the CMS-37 form the state will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2c.

   CMS will make Federal funds available based upon the State's estimate, as approved by CMS.

Within 30 days of the end of each quarter, the State will submit the CMS-64 form quarterly Medicaid expenditure report, showing MaineCare expenditures made in the recently closed quarter.

Maine will submit all information on the CMS 64.9WAIV and/or 64.9WAIV.P, 64.10WAIV, and CMS 37 forms within the time limitations required by CMS.

CMS will reconcile annual expenditures reported on the CMS-64 form with Federal funding previously made available to the state; CMS will include the reconciling adjustment in the finalization of the annual grant award to the State.

4. CMS will provide Federal Financial Participation (FFP) at the applicable Federal-matching rate for the following, subject to the limits described in Attachment D of CMS Terms and Conditions.

   a. Administrative costs, including those associated with the administration of the Maine HIV 1115 Waiver: Premiums collected under the demonstration will be reported to CMS on the CMS-64 Summary Sheet on Line 9.D. This will allow CMS to share in the collection of such fees. The State will also separately identify these fees on the narrative form and Summary sheet of the CMS-64.

   b. Net expenditures and prior period adjustments of the MaineCare program that are paid in accordance with the approved State Plan: Under the program, CMS will not provide FFP to the extent that the subsidies paid to pharmacies exceed the related rebates received from the manufacturers. If, in any quarter, the State believes subsidies are likely to exceed rebates collected, the State will not request FFP for the estimated difference between subsidies paid and anticipated rebates collected. The state will perform an annual reconciliation of subsidies paid and rebates received 180 days after the end of each Demonstration year. The State will return the Federal share of any subsidies claimed in excess of applicable rebates to CMS. Rebates collected in excess of subsidies paid to pharmacies in any given year will be considered in the calculation of the pharmacy subsidy percentage for the next Demonstration year.

   c. Net medical assistance expenditures made under section 1115 Demonstration authority, including those made in conjunction with the Maine HIV 1115 Waiver Demonstration.

5. The State will certify State/local monies used as matching funds for the Maine Demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

[2] A complete description of Medicaid services covered under the demonstration, according to **C.1. of section IV**, which includes general service categories and the specific services included therein.

General Program Description

Program Overview

The Maine HIV/AIDS Waiver benefit is a five-year demonstration program under which a basic, comprehensive set of services will be provided to those who are both HIV positive and are at or below 250% of the federal poverty level. Based on financial requirements including a spending cap, enrollment for the first year is estimated to be able to include130 enrollees. If enrollment reaches the ceiling, individuals will be placed on a waiting list. The Bureau of Medical Services will work with CMS personnel prior to implementation of any changes if it is anticipated that the enrollment cap or FPL ceiling could be raised or lowered.

There are co-payments of $10 for physician office visits and for each prescription. Members under age 21 are exempt from these co-payments. All other MaineCare co-payment rules apply. For individuals above 150% of FPL will be required to pay premiums that are tiered based on income and will rise 5% annually.

Individuals with other insurance may be members of this benefit. The Bureau of Medical Services may pay premiums/cost-sharing for this insurance according to current MaineCare rules.

Requirements to receive benefits under this demonstration are:

- Positive HIV status
- Financially eligible
- Willingness to sign informed consent that includes
  - Understanding of requirements of the benefit
  - Willingness to comply with treatment recommendations
- Fill out information sheet relating to other insurance (TPL)
- Payment of premiums (if applicable)

Services

This is a disease management model whose goal is to delay, prevent, or even reverse the progress of HIV/AIDS. A copy of NIH guidelines as of September 2001 appears as **Attachment III**.

The benefit will provide a circumscribed essential package of services that includes:

a) All medications covered by MaineCare;
b) physician services;
c) laboratory and x-ray;
d) case management services;
e) ambulance;
e) transportation (to covered services);
f) hospital services;
g) mental health and substance abuse services

The following MaineCare categories of services and respective policies of the MCBM are included in the benefit.

General Category of Service	Specific Services Include
Inpatient	MCBM Chapter II, Section 45, Hospital Services
Psychiatric Facility	MCBM Chapter II, Section 46, Psychiatric Facilities Services
Outpatient	MCBM Chapter II, Section 45, Hospital Services
EPSDT Examinations	MCBM Chapter V, Section 3, EPSDT Examinations: Physician Services (Soon to be renamed MCBM Chapter II, Section 94, Prevention, Health Promotion and Operational Treatment Services)
Medications	MCBM Chapter II, Section 80, Pharmacy Services
Community Support Services	MCBM Chapter II, Section 17, Community Support Services
Lab & X-ray	MCBM Chapter II, Section 55, Laboratory Services and Section 101, Medical Imaging Services
Transportation	MCBM Chapter II, Section 113, Transportation Services; benefit will only pay for transportation to covered services
Ambulatory Care	MCBM Chapter II, Section 3, Ambulatory Care Clinic Services; Section 4, Ambulatory Surgical Center Services
Case Management	MCBM Chapter II, Section 13.07, Targeted Case Management Services for Persons with HIV Infection; Section 13.06, Case Management Services for Persons with Severe and Disabling Mental Illness
Family Planning	MCBM Chapter II, Section 30, Family Planning Agency Services
Mental Health	MCBM Chapter II, Section 65, Mental Health Services
Ambulance	MCBM Chapter II, Section 5, Ambulance Services
Psychology Services	MCBM Chapter II, Section 100, Psychological Services
Medicare Crossover-A	MCBM Chapter II, Section 45, Hospital Services
VD Screening	MCBM Chapter II, Section 150, VD Screening Clinic Services
Medicare Crossover-B	MCBM Chapter II, Section 90, Physician Services; Section 31, Federally Qualified Health Center Services; Section 103, Rural Health Clinic Services
Child Health	MCBM Chapter II, Section 90, Physician Services; Section 31, Federally Qualified Health Center Services; Section 103, Rural Health Clinic Services
Physician and Physician Assistant	MCBM Chapter II, Section 90, Physician Services; Section 31, Federally Qualified Health Center Services; Section 103, Rural Health Clinic Services
Home-Based Mental Health	MCBM Chapter II, Section 37, Home-Based Mental Health Services

General Category of Service	Specific Services Include
Early Intervention	MCBM Chapter II, Section 27, Early Intervention Services
Development and Behavioral Clinical Services	MCBM Chapter II, Section 23, Developmental and Behavioral Clinic Services
Substance Abuse Treatment	MCBM Chapter II, Section 111, Substance Abuse Treatment Services
Advanced Practice Registered Nursing	MCBM Chapter II, Section 14, Advanced Practice Registered Nursing Services; Section 90, Physician Services

The following MaineCare categories of services and respective policies of the MCBM are NOT included in the benefit.

General Category of Service	Services Do Not Include
Adult Family Care	MCBM Chapter II, Section 2, Adult Family Care Services
Consumer Directed Attendant	MCBM Chapter II, Section 12, Consumer Directed Attendant Services
Home and Community-Based Waiver Services for Adults with Disabilities	MCBM Chapter II, Section 18, Home and Community-Based Waiver Services for Adults with Disabilities
Home and Community-Based Waiver Services for Persons with Mental Retardation	MCBM Chapter II, Section 21, Home and Community-Based Waiver Services for Persons with Mental Retardation
Private Non-Medical Institution	MCBM Chapter II, Section 97, Private Non-Medical Institution Services
Day Health	MCBM Chapter II, Section26, Day Health Services

General Category of Service	Services Do Not Include
Home Health	MCBM Chapter II, Section 40, Home Health Services
Hospice	MCBM Chapter II, Section 43, Hospice Services
Medical Supplies and Durable Medical Equipment	MCBM Chapter II, Section 60, Medical Supplies and Durable Medical Equipment
Nursing Facility	MCBM Chapter II, Section 67, Nursing Facility Services
Optician	MCBM Chapter II, Section 75, Optometry Services
Physical Therapy	MCBM Chapter II, Section 85, Physical Therapy Services
Private Duty Nursing and Personal Care	MCBM Chapter II, Section 96, Private Duty Nursing and Personal Care Services
Primary Care Case Management	MCBM Chapter II, Section 13, Targeted Case Management Services
School Based Rehabilitation	MCBM Chapter II, Section 104, School Based Rehabilitation Services
Speech-Language Pathology	MCBM Chapter II, Section 110, Speech-Language Pathology Services
Licensed Clinical Social Worker	MCBM Chapter II, Section 58, Licensed Clinical Social Worker Services
MaineNET	MCBM Chapter VI, Section 3, MaineNET
Mandatory Managed Care Initiative	MCBM Chapter VI, Section 2, Mandatory Managed Care Initiative
Audiology	MCBM Chapter II, Section 10, Audiology Services
Chiropractic	MCBM Chapter II, Section 15, Chiropractic Services
Home and Community-Based Waiver Services for the Elderly	MCBM Chapter II, Section 19, Home and Community-Based Waiver Services for the Elderly

General Category of Service	Services Do Not Include
Home and Community-Based Waiver Services for the Physically Disabled	MCBM Chapter II, Section 22, Home and Community-Based Waiver Services for the Physically Disabled
Dental	MCBM Chapter II, Section 25, Dental Services
Hearing Aids and Services	MCBM Chapter II, Section 35, Hearing Aids and Services
Day Treatment	MCBM Chapter II, Section 41, Day Treatment Services
ICF-MR	MCBM Chapter II, Section 50, ICF-MR Services
Genetic Testing and Clinical Genetic Services	MCBM Chapter II, Section 62, Genetic Testing and Clinical Genetic Services
Occupational Therapy	MCBM Chapter II, Section 68, Occupational Therapy Services
Optometry	MCBM Chapter II, Section 75, Optometry Services
Podiatric	MCBM Chapter II, Section 95, Podiatric Services
Day Habitation Services for Persons with Mental Retardation	MCBM Chapter II, Section 24, Day Habitation Services for Persons with Mental Retardation
Rehabilitative Services	MCBM Chapter II, Section 102, Rehabilitative Services
Speech and Hearing Agencies	MCBM Chapter II, Section 105, Speech and Hearing Agencies

Eligibility Determination

Participants must apply for MaineCare coverage by filing a standard MaineCare application with the Bureau of Family Independence (BFI) where a determination of financial eligibility is made. When an application is received with a positive HIV status indication, BFI will ask the Bureau of Health (BOH) to confirm HIV status. This is the medical determination. These two determinations (medical and financial) will be made concurrently. Waiver eligibility will be evaluated by BFI based on the financial and medical eligibility of the applicant. BOH staff will determine medical eligibility through documentation of positive HIV test results provided by the applicant, the applicant's health care

provider, or the applicant's case management provider. Applicants can provide documentation of positive HIV test results from a medical provider or public HIV test site; HIV positive status is the only medical eligibility requirement. BOH will notify the client and BFI in writing of the medical eligibility assessment outcome. If medically and financially eligible, BFI will authorize MaineCare coverage for the Waiver benefit. BFI will send the both the client and BOH appropriate written notification of coverage.

The MaineCare Eligibility Manual will be the reference for application processing standards. Section 1431 states, "All applications must be acted upon and a decision made as quickly as possible." The applicant must be sent a notice of the decision no later than 45 days after the date of application. If a decision of eligibility is not made within 45 days and there is no documentation that the applicant or the applicant's source of medical information has not cooperated in obtaining information necessary to make a decision, temporary Medical assistance must begin on the 46th day."

If the reason for a delay beyond the 45-day processing standard is due to the applicant's failure to provide information or failure by the applicant's source of medical information to provide information, then temporary eligibility will not be granted. If there is evidence that the applicant or their source of medical information is attempting to provide the missing information, then the application will be held in pending status until the information is provided.

When it is necessary to obtain medical reports from physicians, hospitals, or other medical sources, such medical information must be requested from all necessary sources within five days of the application date. If the reports are not received within fifteen days of the first request a second request must be sent. The applicant will be notified when a second request is made, to inform the individual that the necessary medical reports have not been received. Twelve months after initial eligibility has been granted, and annually thereafter, an eligibility review form will be sent to members. Recent income will be verified to determine if the member continues to qualify for the HIV Waiver benefit, and to review the appropriate premium level. If his/her income has decreased, the possibility of non-Demonstration MaineCare eligibility will be determined (note: there is no premium for someone on a waiting list).

Waiting List

The Bureau of Health will maintain a waiting list. When BMS staff advise BOH staff that the cap has been reached, an applicant's medical eligibility will be determined; eligible individuals will be placed on the waiting list in the order that applications are received by BFI. An applicant may request a place on the waiting list by filing an application for MaineCare with BFI under the HIV Waiver.

Co-payments and Premiums

Recipients of the Waiver benefit are responsible for payment of a monthly premium, dependant on their income level. There is a $10 co-pay per medication (maximum of 30-day supply), and a $10 co-pay per doctor's visit, in addition to all standard MaineCare co-payments. Co-payment information will be publicly available to applicants and members at all times; it will appear in the benefit brochure, and will be an integral component of benefit advertising. Waiver co-payments will be collected as any other co-payment would be at the time of treatment. Each Waiver member will carry a card indicating their participation in a limited benefit program without advertising their HIV status. Medication and physician visit co-payments are expected to remain level at $10. Available funding from other sources will be leveraged to assist needy participants with the co-payments.

Income Level	Monthly Premium

Income Level	Monthly Premium
Less than 150% of Federal Poverty Level	0
Between 150% - 200% of Federal Poverty Level	$20
Between 200% - 250% of Federal Poverty Level	$40

Premiums will be inflated by 5% annually, according to the following schedule:

Year	Gross Premium, Adjusted for Inflation	Actual Premium, Income level <150% Poverty	Actual Premium, Income level 150-200% Poverty	Actual Premium, Income level 200-250% Poverty
0	80	$0	$ 20.00	$ 40.00
1	84	$0	$ 21.00	$ 42.00
2	88	$0	$ 22.05	$ 44.10
3	93	$0	$ 23.15	$ 46.31
4	97	$0	$ 24.31	$ 48.63
5	102	$0	$ 25.53	$ 51.06

Although it is supported by MaineCare, the HIV Waiver benefit is not an entitlement program. It is a disease management program with defined treatment protocols. A candidate for the benefit must agree to be monitored and participate in medical treatment. Participants must meet certain eligibility requirements and must follow treatment recommendations after being accepted to the benefit. Participants may also be responsible for the payment of monthly premiums depending on their income level. Each applicant will indicate their understanding and agreement to the waiver's requirements by signing a consent form at the time of application (**Attachment VII).**

The Maine HIV Waiver benefit is only one avenue for services and treatment for low-income individuals with HIV/AIDS. Those who are not eligible to participate in the benefit will still be able to access services currently available through the Ryan White Program and other community-based organizations and providers across the State, including basic (non-Waiver) MaineCare.

Medications

All medications are covered under the benefit for people living with HIV/AIDS as specified in Chapter II, Section 80 (Pharmacy Services) of the MaineCare Benefits Manual.

Ambulance and Transportation

Ambulance and Transportation Services are covered as specified in Chapter II, Section 113 (Transportation Services) of the MaineCare Benefits Manual and Chapter II, Section 5 (Ambulance Services) of the MaineCare Benefits Manual.

Requests for non-ambulance transportation necessary to reach medical services covered by this benefit may be made by appointment to a transportation agency serving the area where the member resides. Recipients who need assistance with locating a transportation agency may obtain relevant

information from the nearest Regional Office of the Department of Human Services. The transportation agency will arrange transportation in the most economical manner that is suitable to the member's medical needs.

Laboratory and X-Ray Services

Laboratory and X-Ray Services are covered as specified in Chapter II, Section 55 (Laboratory Services) and Chapter II, Section 101 (Medical Imaging Services) of the MaineCare Benefits Manual.

Mental Health and Substance Abuse Treatment Services

Mental Health Services are covered as specified in Chapters II, Section 46 (Psychiatric Facilities Services), Section 17 (Community Support Services), Section 65 (Mental Health Services), Section 100 (Psychological Services), Section 37 (Home-Based Mental Health Services), and Section 23 (Developmental and Behavioral Clinic Services) of the MaineCare Benefits Manual. Substance Abuse Treatment Services are covered as specified in Chapter II, Section 111 (Substance Abuse Treatment Services) of the MaineCare Benefits Manual.

Physician Services (including Physician Assistant)

Physician Services include services provided by Physician Assistants, and are covered as specified in Chapter II, Section 90 (Physician Services) of the MaineCare Benefits Manual. Members will also have the option of receiving physician services through Federally Qualified Health Center (FQHC) Services (Section 31); Rural Health Clinic (RHC) Services (Section 103); and Chapter V, Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT), soon to be renamed Chapter II, Section 94, Prevention, Health Promotion and Optional Treatment Services of the MaineCare Benefits Manual.

Advance Practice Registered Nursing Services

Advance Practice Registered Nursing Services are covered as specified in Chapter II, Section 14 (Advance Practice Registered Nursing Services) and Chapter II, Section 90 (Physician Services) of the MaineCare Benefits Manual.

Hospital Services

Hospital Services are covered as specified in Chapter II, Section 45 (Hospital Services) of the MaineCare Benefits Manual.

Case Management Services

Case Management Services are covered as specified in Chapter II, Section 13.07, Targeted Case Management Services for Persons with Human Immunodeficiency Virus (HIV) Infection and Chapter II, Section 13.06, Case Management Services for Persons with Severe and Disabling Mental Illness of the MaineCare Benefits Manual.

Early Intervention Services

Early Intervention Services are covered as specified in Chapter II, Section 27 (Early Intervention Services) of the MaineCare Benefits Manual.

Ambulatory Services

Ambulatory Services are covered as specified in Chapter II, Section 3 (Ambulatory Care Clinic Services), and in Chapter II, Section 4 (Ambulatory Surgical Center Services) of the MaineCare Benefits Manual.

Family Planning Agency Services

Family Planning Agency Services are covered as specified in Chapter II, Section 30 (Family Planning Agency Services) of the MaineCare Benefits Manual.

VD Screening Clinic Services

VD Screening Clinic Services are covered as specified in Chapter II, Section 150 (Family Planning Agency Services) of the MaineCare Benefits Manual.

[3] A description of the State's plan to foster coordination of care between the primary care provider and other entities such as public health departments, community health centers, Ryan White providers, etc. Refer **C.2. of section IV**.

Coordination/Case Management

Under the HIV Waiver benefit, a new clinical and social coordination of case management is proposed. Although coordination of care and case management currently exists among HIV providers, public health departments, community health centers, Ryan White providers, and others, Maine DHS has proposed using the new Waiver as an opportunity to increasingly focus on collaboration issues. Case management is not currently reimbursable for many HIV positive individuals in Maine. This Waiver will allow further reimbursement for case management services in Maine. All HIV positive MaineCare members will be followed closely for both cost and quality indicators. This will allow identification of members whose cost profile or quality of care profile suggest less than optimal coordination. The Medical Director and Program Manager will work with these individual members and case management and provider resources to try to improve the quality of care as well as improve cost-effectiveness.

The Bureau of Medical Services Medical Director and the Director of Quality Improvement will provide program oversight. A Health Program Coordinator will be employed by the Bureau of Medical Services and will maintain a formalized communication link with HIV Service Organizations (HSO's) and, as

needed, with members and providers. The MaineCare Physician Advisory Committee will be used as a resource to review care and treatment protocols, practices, and management with input as needed from an Infectious Disease Consultant with HIV/AIDS expertise. The Bureau will arrange for periodic provider education and training with appropriate clinical experts. The Medical Director and Director of Quality Improvement will monitor population trends.

The HIV Waiver benefit is intended for all benefit-eligible people living with HIV or AIDS in the state of Maine, including people with disabilities. The Medical Director and Director of Quality Improvement will ensure that the benefit provides services that are accessible to all disabled people, including hearing impaired, vision impaired, and physically disabled enrollees.

The HSO's will be encouraged to hire nurse case managers to diversify the skills of their case management staff. If HSO caseloads increase by the expected 25-30% as a result of the Waiver benefit, the resulting additional fee-for-service billings can be used to hire any necessary supplementary staff. All case managers will be expected to help clients adjust to their illness, provide teaching associated with their care, support medication adherence, and to coordinate, broker, and expedite access to needed resources. In addition, case managers will be responsible for ensuring that each client has access to a primary care physician: referral to primary care will be an integral part of benefit care delivery. Clinical case managers will have advanced skills in applying a clinical reasoning process, monitoring the clients' clinical status and health behaviors, and teaching regarding health-related issues and behaviors. They will act as a liaison between AIDS-related support systems and the crucial medical management team. AIDS case managers can access area-appropriate provider, hospital, and specialist listings through the local Bureau of Health office.

Within an HSO, clients should be assigned to case managers based on the complexity of their needs, the type of service required (clinical vs. social), and the frequency or intensity of contact required. Since HSOs may have three types of case managers—social workers, social work assistants, and nurses—a triage system should be maintained to assist in case assignment.

It is estimated that 50-60% of persons with HIV/AIDS require some type of Mental Health and/or Substance Abuse intervention. A consistent theme throughout interviews with clients, case managers, and providers is the need to integrate these services more closely with other medical and social services. The benefit care coordination model proposes that formal linkages be made by the HSOs with a local primary care physician, the specialist physician, and both mental health and substance abuse professionals in order to decrease care fragmentation and increase continuity.

[4] A description of the State's outreach and marketing strategy, in accordance with requirements in **A.1. of section IV**, including the availability of bilingual materials/interpretation services and services for individuals with special needs. Include any pertinent documentation of the State's strategy, including informational brochures or materials that will be used as an attachment to the Protocol document.

Outreach Strategy

The Outreach Strategy will include a marketing plan which:

1. Is statewide: covers both urban and rural areas;
2. Uses several types of media: print, radio, public forums, and direct communication with HIV community services projects and AIDS specialist physicians;
3. Is aimed at getting information to various benefit constituencies: patients, physicians, social service agencies, hospitals;
4. Provides the following information in an easy to understand format: services covered, eligibility requirements, details of premiums and co-pays, where to apply and who to call for further information;

5. Addresses the needs of minority (race and language) and disabled populations.

A comprehensive list of resources will also be made available to all constituencies (these lists appear as **Attachment III.**).

An informational brochure, poster, newspaper advertisement and radio text have been developed and appear as **Attachment V**.

The following is an outline of the proposed outreach strategy for the benefit. All materials included in the benefit will be designed in an easy-to-understand format and patient-focused materials will be created at an appropriate literacy level. As needed, the materials can be translated and made available in foreign languages or transcribed into other formats. The same linguistic and culturally competent services available to MaineCare members will be available to potential enrollees in the HIV Demonstration Project.

The strategies described below are designed to increase awareness among the key outreach constituencies: patients, providers, physicians, hospitals, pharmacies, outreach and community organizations and others. The campaign will encompass the entire state of Maine, covering both urban and rural geographic regions. The facets of the campaign, while aimed at different audiences, are designed to complement each other and to reinforce a consistent message.

Outreach to Patients

Press Kit & Public Relations:
A press kit will be developed, and will contain a program fact sheet, brochure, bulleted benefit details, reproducible logos and public service announcements, Q&A, press releases, and contact information. The kit will be used to convey complete and accurate information to the press and other interested parties.

This kit will be sent to newspapers (daily, weekly, monthly. etc.) and radio stations within the state. Interview opportunities will be solicited with major media to promote benefit awareness and to ensure statewide coverage. Benefit officials will be made available to local media for interviews, call-in shows and appearances.

The press kit will reach all constituencies, but its primary aim is to raise awareness of the benefit among patients and potential enrollees.

Public Service Announcements
Public service announcements will be made available to media throughout the state, along with a letter from benefit officials explaining the benefit and asking for cooperation in the public service campaign.

Announcements will focus on the availability and location of services. Announcements will be structured so that they can be customized for use either by the benefit or by participating providers. They will not be specific in details, but will inform of new available services and how to get more information. They will also indicate that all calls/inquiries will be confidential.

Posters & Brochures
A brochure detailing services has been created for use at all possible points of contact. Brochures will be sent to physicians, hospitals, clinics, pharmacies, special projects, outreach facilities, community facilities, town halls and other relevant locations. They detail the services provided, the eligibility guidelines, and how to initiate contact with the benefit. Several ways to access further information will be provided, including toll-free telephone numbers and local community contacts.

A Q&A piece will be developed to send to qualified individuals and organizations that request such information; it will describe the benefit in much greater detail. The Q&A piece will cover premiums, detailed eligibility guidelines and other more complex benefit details. Community workers can also use this piece when explaining the benefit to interested applicants.

A poster has been developed announcing the availability of the benefit. Posters will be sent to physicians, hospitals, pharmacies, community organizations and town halls for display.

Toll-Free Telephone Hotline
A toll-free telephone number will be provided to take confidential inquiries, answer questions, field requests for more information and to make referrals for other services as necessary. This number is 1-866-796-2463.

Outreach to Physicians, Hospitals & Pharmacies

Direct Mail
A comprehensive packet detailing the benefit will be sent or delivered by benefit personnel to physicians, hospitals and pharmacies. It will contain a letter outlining the highlights of the benefit and offering personal assistance as needed. It will contain the details of the benefit from both the patient and provider perspectives. Detailed materials for use by these professional individuals will be enclosed as appropriate, including forms, Q&A, and policies and procedures information. A copy of patient materials will be enclosed, along with an order form for agencies to request additional materials.

Professional Forums
A series of forums will be held throughout the state to explain the benefit to potential providers and associated professional services. Forums will be held regionally in hospitals or other settings and will be an opportunity both to explain the details of the benefit and to answer questions. Benefit personnel will attend these sessions, make presentations, and answer questions. Benefit personnel will also explain the other components of the outreach campaign and solicit feedback from the professional services community.

Toll-Free Provider Support
A toll-free provider support line will be accessible for quick access to benefit personnel, answers to questions, and timely problem-solving. This number is 1-800-321-5557.

Outreach to Community Agencies, HIV Community Service Projects & AIDS Specialist Physicians

Direct Mail
As with hospitals, a complete packet of information will be sent or personally delivered to appropriate outreach organizations. The packet will contain forms, Q&A, policies and procedures manuals, patient-focused materials and other items as needed.

Community Outreach Meetings
Similar to the professionals' forums, a series of regional forums will be held between benefit personnel and community service projects. These will be an opportunity for benefit officials to describe the details of the benefit, answer questions, discuss community outreach strategies and to present relevant materials. The meetings will focus on opportunities for participation among project clients and strategizing community outreach options.

Joint Outreach Projects
Specialized materials or outreach may be developed within a specific service area for use by local community service projects or physicians. If a particular agency can identify an action or event that would be effective in their service area, an adaptation of existing materials will be created to suit their needs.

Customized Media Materials
A set of public relations materials may be made available to certain organizations for facilitating benefit promotion through established contacts with local press. Training on press relations will be provided if necessary.

[5] A comprehensive description of the education, enrollment, and disenrollment processes. Include any enrollment forms or informational items, including the State's consent form (referenced in **A.4. of section IV**) in an attachment to the Protocol document. Also include a detailed description of the State's method for verification of HIV seroconversion for enrollment into the demonstration. Refer to also to **A.1. of section IV**.

General Overview Followed by Enrollment and Disenrollment Policy Information

Enrollment

Three conditions must be satisfied for enrollment in the HIV Waiver benefit: HIV diagnosis, financial eligibility, and client willingness and ability to participate in and adhere to treatment recommendations. The Bureau of Family Independence (BFI) will determine an applicant's financial eligibility for MaineCare, and update the enrollment information system with appropriate financial eligibility data. The Bureau of Health will do the medical assessment and notify BFI of the determination. When proper determinations have been made by both Bureaus, the application is complete.

The HIV Waiver benefit will require changes in the enrollment forms currently in use by both departments. Only people on Expansion will be coded for BFI purposes. All members who get MaineCare benefits have an eligibility or program code, not just those receiving the HIV benefit. HIV demonstration recipients will have a distinct program code. When Waiver eligibility begins or ends, or is converted to full benefits MaineCare status, this code's effective dates will be updated by BFI.

There is already a system in place to differentiate clients in order to trigger co-payment charges and to allow hospitals to exclude these clients from Disproportionate Share - the HIV Waiver will follow the existing protocol.

The following existing forms will be used to enroll clients in the benefit:

1. Any one of the MaineCare applications available from BFI
2. Assignment of rights to medical insurance
3. Long Term Care Message Form (though long term care is not included in Waiver coverage)
4. Consent to Disclosure of HIV Test Results to the Department of Human Services
5. Informed consent form, stating that the member understands the benefit

These forms, which include changes to accommodate the HIV Waiver, appear as **Attachment VI**.

Confidentiality

All HIV waiver benefit applicants will sign a document allowing the release of HIV test results to the Department of Human Services, allowing the Bureau of Medical Services (BMS), the Bureau of Family Independence (BFI), and the Bureau of Health (BOH) to obtain test results from the applicant's healthcare provider or HIV case worker. Information will be used to establish benefit eligibility, manage the program, and allow Quality Improvement activities. The only financial information needed for eligibility will either be provided by the enrollee or requested in exactly the same, confidential manner as would be utilized for application for any other MaineCare program, and will not identify applicants to the HIV waiver benefit as HIV positive. There is no asset test for benefit eligibility. In addition, BMS will be sensitive to confidentiality issues in all mailings, letters, and interactions with other agencies and

members. BMS will comply with all Maine Statutes and MaineCare confidentiality policies. Each member's MaineCare card will list only that the member has "limited benefits" and will not identify the member as HIV positive. MaineCare is committed to HIPAA compliance in all systems and policies.

Procedure

1. A client will request MaineCare coverage from the BOH, a Ryan White caseworker, or directly from BFI. They will be given a MaineCare application (**Attachment VII)**, and instructed to send it or take it to the appropriate BFI office. The date of application is the date the application is received by BFI. When an application is submitted to BFI, the BOH will be immediately notified, via FAX, of the application so they can determine medical eligibility (HIV status). When the BFI caseworker has knowledge of the existence of a prior HIV test, either a copy of the test results or the information where the test results are available will be provided to BOH. In instances where there is no known test result the BOH will instruct the applicant of available test sites. BOH will follow-up directly with the applicant to verify the results of the test. If the client is medically ineligible when BOH makes the medical eligibility decision, BOH will directly notify the client of the medically ineligible decision and the reasons for their decision. BOH will also notify BFI of the medical ineligibility status; BFI will separately notify the client of Waiver benefit ineligibility, after eligibility for all MaineCare coverage groups has been determined.

If the client is found to be medically eligible, BOH will notify BFI of this decision so the financial eligibility determination can be completed. BFI will then notify the client of the final eligibility determination of their application, and confirm their admission to the benefit.

If the client is placed on the Waiting List they will receive a letter from BOH notifying them of their status, and explaining that the client must also be found to be both medically and financially eligible before coverage can start.

The medical and financial determinations will be made concurrently, but BFI cannot authorize MaineCare coverage under the HIV Waiver benefit until it receives confirmation of medical eligibility from BOH. BFI will determine if MaineCare eligibility exists using all other coverable group eligibility criteria before granting HIV Waiver benefit coverage, with the exception of when there is a need for a disability decision, as in #2 below.

Financial rules to be used are: the gross monthly income is less than or equal to 250% of the Federal Poverty Limit, counting gross income. SSI-related rules of eligibility will be used in defining income. Consistent with Home Based Waivers, income from one spouse will not be deemed to the other. If a married couple applies for the benefit, financial eligibility will be determined as two separate cases, counting only the individual's income.

2. If the client appears financially eligible for full benefit MaineCare, but a disability determination is needed, BFI will begin the disability determination process and grant the Waiver benefit pending the outcome. Determination of eligibility will not be held up because of disability. If the client subsequently meets the disability criteria, MaineCare coverage under the HIV Waiver would stop and full benefit MaineCare would begin without disruption of care.

3. When BFI gets notice from BOH that the client is medically eligible for the benefit and the client is determined to be financially eligible, both the applicant and BOH will receive a copy of the grant notice. BFI will also inform both parties if an application is denied. Applicants may reapply any time after denial; there is no required waiting period between denial and reapplication.

4. Financial eligibility for HIV Waiver status will be reviewed every twelve months, however interim changes could cause coverage to stop, or convert to full MaineCare prior to the twelve-month

review date. Twelve months after initial eligibility has been granted, and at each twelve-month interval thereafter, an eligibility review form will be sent to members. Recent income will be verified to determine if the member continues to qualify for the HIV Waiver benefit, and to review the appropriate premium level. If the members income has decreased, the possibility of non-demonstration MaineCare eligibility will be determined.

Coordination of Programs

A member who is a member of this benefit will not be included in any other eligibility category simultaneously (e.g. Healthy Maine Prescriptions).

The Application Process From the Client's Perspective

In order to submit an application to BFI, the client will either take the completed MaineCare application to a local BFI office or send it by mail. If the client takes the application to a local office a caseworker will see them on the premises. If the application is sent, a BFI caseworker will contact the client by mail or phone. The client will be:

- Asked to provide proof of gross income sufficient for the caseworker to determine their average monthly income.
- Given a brochure that explains their requirement to agree to adhere to optimal medical care. The brochure explains that they may have to pay a monthly premium, and prescription and physician visit co-payments, in addition to standard MaineCare co-payments. Other brochure information includes the possibility of waiting-list status, names, addresses, and phone numbers of DHS offices statewide, and state and national AIDS hotlines which can provide additional resource information, including HIV test sites.
- Asked to sign a consent form authorizing the release of their HIV test results to BFI, BMS, and BOH. If the client has not been tested, BOH will provide information on test sites. and the client will be given an information release form and a contact person at BOH. The client will then arrange for a test to be performed, list the test site on the release form, and return it to BOH.
- Asked to sign an informed consent form indicating the applicant's understanding of the following: their participation in the benefit is voluntary; a condition of eligibility is compliance with their medical treatment plan, as outlined by their doctor or doctors; the HIV Waiver benefit is not the full MaineCare benefit; if they become eligible for full MaineCare their coverage will be changed to full benefits without disruption of care; co-payments and benefits are the responsibility of the member; and that there is a waiting list, should the benefit reach capacity.

Within a few days the client will receive notification and acknowledgement of their application, explaining the processing time frame of 45 days.

If the client is found to be medically ineligible they will receive notification of this from BOH. Shortly thereafter, BFI will send them a notice denying participation in the benefit and granting or denying full benefit MaineCare.

If BOH determines that the client must be placed on a waiting list, they will receive a notice directly from BOH. When BOH is notified by BMS that an opening in the program has occurred, they will notify BFI of the name and current address of the individual on the waiting list so that a financial review can be completed. If the individual continues to meet the program's financial standards, they will be enrolled.

Related Enrollment Issues

ADAP enrollees will have the option to enroll in the Waiver benefit. If they choose not to apply they will remain in the ADAP program. Those who choose to apply to the Waiver and are determined to be

eligible will be required to leave the ADAP program and enroll in the Waiver benefit. BFI will work with BOH to facilitate a timely transition of ADAP participants to the HIV benefit.

The premium/co-payment requirement of the Waiver may be a hardship for transitioned ADAP clients. Participants will be informed that the major benefit in participating in the Waiver is that the range of services is wider than under ADAP. Waiver benefit services include highly active anti-retroviral therapy (HAART), other medications, physician office visits, laboratory tests, monitoring, case management, social services, and hospitalizations. The goal of the benefit is very proactive: to delay, prevent, or even reverse the progress of HIV/AIDS. The premiums are tied to level of income, and range from $0 to $40 per month. The co-payments are $10 per medication and $10 per physician office visit, as well as other standard MaineCare co-payments. They compare very favorably to private insurance premiums and medication co-payments, which are extremely high.

If financially eligible, client coverage under the HIV Waiver benefit will be retroactive three months prior to the date of application, but not prior to the date of medical eligibility as determined by the BOH medical assessment or prior to the benefit start date. Waiver premiums will be waived for the retroactive period, as BFI has no capacity to collect and record retroactive premiums.

Maine Statutes, Chapter 501, § 19203, dictates the circumstances under which the results of an HIV test can be made available to another person or organization. Upon applying for the HIV Waiver, the applicant will be asked to sign a release form to disclose the results of an HIV test to the Department of Human Services, including the Bureau of Family Independence (BFI), the Bureau of Health (BOH), and the Bureau of Medical Services (BMS). This release form may be revoked at any time, and is valid for not longer than one year. The results of an HIV test—either from the applicant or from a medical source—will be sent directly to BOH, since it is BOH's responsibility to verify medical eligibility for participation in the HIV Waiver benefit. BFI will receive a medically eligible or not notification from BOH. No HIV test results will be maintained in the BFI case record. Individual employees of BFI must annually sign an acknowledgement of receipt of the confidentiality policy of the Department of Human Services.

Disenrollment

There are several ways in which a benefit recipient can become ineligible for the benefit. Among them are the following:

- Income rises above 250% of Federal Poverty Level.
- Non-compliance with the medical treatment recommendations.
- Non-compliance with the procedure for returning twelve month review form.
- Non-payment of monthly premiums (loss of eligibility after a grace period).

There are also circumstances which will move a client from Waiver Expansion to full benefit MaineCare status, such as the determination of permanent disability. If an individual becomes benefit-ineligible their case will be reviewed by BFI prior to disenrollment, in order to determine possible eligibility under another benefit.

Determination of Non-compliance

Concerns regarding non-compliance by a member receiving the benefit for people living with HIV/AIDS may be brought to the attention of the Bureau of Medical Services (BMS) Medical Director in writing by any of the following parties:

- Medical provider;
- Case worker; or

- Quality assurance/HIV Waiver personnel.

Upon notification of a member's potential non-compliance, the BMS Medical Director will request and review the member's medical records. If the evidence supports substantial non-compliance, the case will be forwarded to the HIV/AIDS medical consultant and the Physician Advisory Committee.
If the Physician Advisory Committee, in conjunction with the HIV/AIDS medical consultant concur, the following actions may be taken.

- Termination from the MaineCare Benefit
- Notice of failure to comply with recommendations and a reasonable time frame to comply
- Continued review
- No action

If benefits are terminated, the member, provider, and Bureau of Family Independence will be notified in writing by the BMS Medical Director at least 30 days prior to benefit termination. The member will have rights to an administrative hearing as outlined in the MaineCare Benefits manual.

Members terminated from the benefit for non-compliance will not be able to re-enroll for the benefit until 3 full months have passed from the date benefits ceased. If a waiting list exists, they will be placed on the waiting list according to the date their re-application is received by BFI, but no earlier than 3 full months after benefits terminated.

[6] A discussion of the State's plans to limit enrollment via an enrollment ceiling. The State should describe the mechanism by which Maine will implement the enrollment ceiling, how the enrollment ceiling number will be derived, and assurances that demonstration enrollees will remain on the program as long as they are eligible (even if the enrollment ceiling number is lowered throughout the course of the 5 year demonstration). The State and HCFA will work together to determine a process for amending the enrollment ceiling number. Please answer in accordance with **B.1**. **of section IV**.

Enrollment Ceiling

Application and enrollment will be through BFI regional offices, which will ensure that an enrollment cap is applied to the Waiver benefit. BFI offices already have a protocol in place for collecting premiums—sending out monthly bills and processing payments—since the current CHIPs and MaineCare expansion require some premium payments.

The enrollment cap number is derived by monitoring actual total and PMPM expenditures over time, as referenced in the following table. If the PMPM costs exceed the budget, the enrollment ceiling will be adjusted so that the actual expenditures return to budget (i.e., by freezing enrollment), though once on the Waiver, enrollees will remain on, even if the benefit ceiling is lowered. It is estimated that the actual starting enrollment number will be130 clients. No changes in the enrollment ceiling or FPL limits will be made without prior approval by CMS.

Year	Cumulative target / Med & Expansion	Allowed Margin
1	$12M	8 pct
2	$23M	3 pct
3	$33.9M	1 pct
4	$45M	.5 pct
5	$56M	0 pct

If members have existing health coverage, MaineCare may use Waiver benefit funds to pay private healthcare premiums.

In the Private Health Insurance Premium Program (PHIPP) a member is eligible for MaineCare, and it is cost effective to pay the private health insurance premium to reduce or eliminate MaineCare expenditures. Members' medical expenses will be reviewed on a quarterly basis under this option to determine continued cost effectiveness.

Title 22, Subsection 18, Condition for Eligibility, states that, "as a condition of being or remaining eligible for medical assistance, an individual otherwise entitled to medical assistance under this Title to apply for enrollment in a group health plan in which the individual is otherwise eligible to be enrolled, if the department determines that enrollment is cost-effective". Therefore, it would appear that since recipients of the HIV/AIDS Waiver benefit are required to be MaineCare eligible that they would also meet eligibility under this Title to participate in PHIPP if it is determined that it is cost effective. Under the Waiver, hospitals and other providers will submit claims using standard MaineCare claim systems, and MaineCare will use standard systems for processing claims under the Waiver.

[7] A detailed discussion of the operation of a waiting list, if/when applicable, for the demonstration program. Include any pertinent documentation or instructions for the waiting list as an attachment to the Protocol document. Answer in accordance with **B.3. of section IV**.

Waiting List

The HIV Waiver benefit has a budgetary cap which allows for approximately 130 people to participate in the program in the first year. As a result, all slots may become filled. To assure a fair and orderly transition of applicants into openings formed when members leave the benefit, a waiting list will be maintained. Responsibility for the waiting list will be with the Bureau of Health, which maintains similar lists for other programs.

Procedure

1. When an applicant is placed on the waiting list by BOH, BFI will determine eligibility for any other MaineCare benefit. Placement on the waiting list will be on a first-come, first-served basis as determined by the date the application is received by BFI.

2. BOH will send the letter confirming a participant's placement on the waiting list.

3. If an opening in the benefit becomes available, BMS will notify BOH. BOH will notify BFI, who will then update the information on the applicant at the top of the waiting list, and process the application.

4. An applicant will be allowed to request a place on the BOH's waiting list by filing a standard MaineCare application directly through BFI, and meeting the financial and medical eligibility requirements.

Related Waiting List Issues

An applicant has the right to know his/her place on the list and, if requested, BOH will release this information to the applicant.

[8] An overall quality assurance monitoring plan that includes a discussion of all quality indicators to be employed and methodology for measuring such indicators; quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys; credentialing requirements and monitoring; fraud control provisions and monitoring; and the proposed provider-enrollee ratios, access standards, etceteras.

Quality Assurance Monitoring

- The Bureau of Medical Services will be responsible for the overall monitoring of the quality of medical care and services provided to all individuals being served under the HIV Waiver benefit. The measurement of quality of care is based on indicators that are linked to optimal clinical care outcomes. Evaluation of the HIV Waiver benefit will be completely independent of other CMS demonstration initiatives simultaneously occurring in the state of Maine.

- All reviews for quality of care will be based on Continuous Quality Improvement (CQI) techniques. CQI-based monitoring strives to reduce variance while constantly working to achieve measurable goals. This is a strategy for ongoing quality improvement that encourages analysis of the system of care rather than the review of an individual provider's performance.

- Results of the quality of care practice level reviews will be presented as aggregate data so that providers can evaluate systems of care underlying outcomes of individual cases. Results will be provided in a format that permits comparative evaluation and benchmarking analysis. BMS staff will use the results to target providers for assistance, not to penalize them.

- In concert with principles of CQI, corrective action will generally be through information feedback and education to clients, caseworkers, and clinical providers. In extreme cases, sanctions as described in Chapter 1, General Policies and Procedures, Subsection 1.19, Sanctions, of the MaineCare Benefits Manual may be employed.

- Separate provider credentialing for the Waiver benefit will not be carried out. All MaineCare participating providers, constituting the great majority of all licensed medical providers in the State of Maine, will be included in the Waiver provider panel.

- Usual MaineCare fraud and abuse systems—as cited in Chapter 1, General Policies and Procedures, Subsection 1.20, Fraud and Abuse, of the MaineCare Benefits Manual—will be employed in the Waiver benefit.

- Providers will be encouraged to analyze data and assess the internal factors that contribute to their overall performance.

- Algorithms will be used as the basic tool for the quality of care program. The newest NIH Treatment Guidelines will inform or guide the algorithms used (these guidelines are included as **Attachment III**). Some algorithms will apply to all persons with HIV, such as HIV staging, antiretroviral therapy, PCP prophylaxis, and PPD performance. Others will apply only to specific conditions or diseases. Therefore, algorithms can be applied on the basis of age, gender, diagnosis, or provider type. The algorithms contain specific performance indicators for measurement which are incorporated into surveillance worksheets and computer software for medical record abstraction. Records will be selected randomly from various data sources as well

as from a list of all available cases covered by MaineCare and the HIV Waiver. Data abstracted will be reviewed and analyzed by BMS Quality Improvement staff.

The Quality Improvement Model is based on several guiding principles

- The use of aggregate data to measure performance
- The measurement of clinical indicators that are based upon clinical practice guidelines
- The provision of CQI consultations which will specifically include quality improvement education
- Building an internal structure for quality in the HIV Waiver benefit
- Promoting support and commitment throughout the organization for quality

Core Indicators

Core HIV indicators will be measured in the following:

- HIV staging (CD4 and viral load measurement)
- Antiretroviral Therapy
- PCP Prophylaxis
- MAC Prophylaxis
- PPD Screening
- GYN Care (Pelvic exam with PAP Smear, STD Screening)
- Specialty Referrals

Quality Indicators

- HIV Staging
- Antiretroviral Therapy
- Opportunistic Prophylaxis
- Tuberculosis Screening
- Gynecological Care
- Substance Abuse
- HIV Counseling and Testing
- Perinatal Transmission Prophylaxis

HIV Quality Assurance

Data Sources

1. Pharmacy claims
2. Medical claims
3. Survey – provider – recipient
4. Lab result submission – HIV viral LOAD – CD4 count
5. Medical record abstraction

QA outcomes/measures

1. Aggregate program – adults/pediatrics
2. Med/waiver
3. Provider level reports

4. Quarterly, annual

1	a. CD4 testing frequency – CPT claims data b. Recipients not being tested
2	a. HIV viral load testing frequency – CPT claims b. Recipients not being tested
3	a. ART regimens (point in time) number, percent on each drug and on each drug combination (pharmacy claims), percent on optimal, less desirable, undesirable. b. Table – overlay ART regimen with most recent CD4/HIV load clinical status data – pharmacy claims report data – lab report submissions
4	PCP prophylaxis – pharmacy claims, medical claims
5	MAC prophylaxis – pharmacy claims, medical claims
6	Nutritional support – number, percent on enteral supplements, appetite stimulants, serostins, etc
7	TB-PPD screening – med claims; record abstraction
8	Female HIV recipients b. PAP rates – medical claims c. PAP results – record abstraction

Pharmacy QA

The Maine Point of Purchase (MEPOP) system for pharmacy claims provides the ability to issue alerts based on drug utilization. Please see description of the MEPOP system in Protocol 10. These alerts include but are not limited to: drug/drug interactions, overutilization, underutilization, drug/disease interactions, refill too soon, duplicate therapy (same drug within previous claim days supply), therapeutic duplication (same drug class as a previous claim). Draft pharmacy edits appear as **Attachment VIII**.

[9] A description of the complaint and appeal policies that will be in place at the State level. Refer to **E.3 of section IV**.

Complaints and Appeals

Policy and procedures for Complaints and Appeals are adopted directly from Chapter I, Sections 1.19 and 1.20.5 (General Administrative Policies and Procedures) of the MaineCare Benefits Manual.

[10] A description of basic features of the administrative and management data system. Refer also to **number 4 of Attachment B**.

HIV/AIDS 1115 Demonstration System Impacts

The Maine HIV/AIDS 1115 Demonstration will impact a number of subsystems within the overall MaineCare Information System. This will describe subsystems impacts and provide a functional description of each. The systems covered are:

- Maine Welfare System (WELFRE)
- Maine Enrollment and Capitation System (MECAPS)
- Maine Medicaid Decision Support System (MMDSS)
- Maine Point of Purchase System (MEPOPS)

WELFRE

Impact: The WELFRE system is a statewide, integrated set of subsystems serving a variety of human services functions. These include the basic member demographics and authorization of MaineCare and SCHIP eligibility from BFI (TANF/ASPIRE, food stamps, MaineCare). It also stores data from Bureau of Medical Services and Bureau of Elder & Adult Services on medical assessments needed to prior authorize certain services, and in some cases together with financial information from BFI the data authorizes MaineCare coverage. Possible Waiver impacts on WELFRE would include the ability to capture eligibility information for an HIV/AIDS recipient, generate eligibility cards for the member on a monthly basis, and include the appropriate edits to ensure MaineCare claims for the member are successfully adjudicated and paid.

Description: WELFRE supports the TANF/ASPIRE, Food Stamp Program, and Medical Services programs. It is mainly a repository of information and data that is pertinent for the determination of eligibility for the programs. It is the source of all member demographics.

The system:

- Collects and stores member's demographic information;
- Issues monthly benefits and Medical identification cards and;
- Provides state and federal reports, member letters, notices and forms.

WELFRE is the repository of member information for people who are eligible for MaineCare services. The system generates Medical ID information that allows member to receive Medical care. It interfaces with MECAPS, MEPOPS and MMDSS systems within the Department to assure that medical care is paid on behalf of the members.

The Automated Client Eligibility System (ACES) will replace the eligibility subsystem on WELFRE in 2002. ACES will provide an automated eligibility capability and staff web-based access to member information. In addition, ACES represents a substantial improvement in the speed and accuracy of benefit delivery to members.

MaineCare Claims Processing: The general path of a claim through the daily claims processing cycle is to count it in inventory, format and edit it, check member and provider eligibility, price it, check for

duplication, count it again in inventory, and either adjudicate it for payment or suspend it for error correction.

MaineCare Financial Processing: The purpose of the Financial Subsystem is to make a periodic determination of remittances to providers based on adjudicated claims and adjustments, financial transactions, and outstanding balances of provider accounts carried forward from prior cycles.

- Records and Reports all transactions affecting this determination
- Reports the results of this determination to the State Controller's check write system for payment and maintains payment history based on transactions and feedback information returned by the Controller's system.

Drug Reference: The drug reference system updates and maintains drug information in conjunction with Gould Health Systems.

Federal Reporting (FRM): Reads the client file and creates the required CMS-372 report, either:

ADW = ADULTS WITH DISABILITIES WAIVER
BMR = BUREAU OF MENTAL RETARDATION
PHY = PHYSICALLY DISABLED WAIVER
BME = ELDERLY WAIVER.

Management and Reporting (MARS): MARS is concerned with producing reports that enable management to effectively control their Title XIX program. MARS provides management with information assisting in fiscal planning and control, evaluation of provider and member participation, evaluation of the process of claims processing operations, and development of medical assistance policies on a monthly basis. A number of the MARS reports may be produced on a weekly, quarterly, semiannual, or annual basis at the user's option.

The MARS subsystem uses a weekly, monthly, quarterly, or annual extract of paid claims to produce reports specified by the users. This subsystem may access the provider, member, and financial information to obtain extracts in order to produce certain reports. MARS also uses the suspense records from claims processing to produce reports on suspended claims. In addition, the member information is occasionally used for producing reports.

MaineCare Provider Information: Maintain computer records of provider-related information, for use by other MMIS subsystems, and meet the reporting needs of the Bureau of Medical Services.
.
Preventative Health Program: The preventive health program, formerly the early preventive screening and diagnostic treatment program, monitors preventive health measures for children on the MaineCare system, including the AMHI Consent Decree administered by the Muskie Institute.

Recipient Information: The major goal of the Recipient Subsystem is to print Medical ID Cards. Federal law does not allow the same subsystem to both create Medical ID card information and print the cards. The information is collected through the Bureau of Family Independence SubSystem.

Surveillance Utilization and Review (SURS): SURS uses the most current version of member records during its information processing. SURS produces reports which allow management to effectively control Title XIX Programs. SURS develops statistical profiles of health care and patterns of utilization which are then used to screen for possible misutilization, fraud, or defects in the quality of services provided. The reports produced by SURS on a weekly, monthly, or quarterly basis provide information that allows fraud checking.

SURS is responsible for monitoring provider and member compliance with MaineCare policies and regulations. Provider reviews are usually initiated by analyses of treatment and payment trends. This is necessary to control fraud, waste and abuse.

Third Party Liability (TPL): The purpose of the TPL subsystem is to track and report paid MaineCare claims that may have been covered by some other form of medical insurance.

MECAPS

Impact: MECAPS determines eligibility and calculates payment rates for managed care based on the geographic region of the recipient and other factors such as MaineCare category group. Supporting the HIV Waiver benefit will likely result in changes within MECAPS, such as changes in the system table.

Description: MECAPS has two basic functions:

1. Eligibility determination for managed care based on members' MaineCare eligibility and geographic residence in the State of Maine. The system tracks the total enrollment process for each individual and involves producing enrollment packet information, follow-up letters, and reminders. The application provides the enrollment broker with information to assist the members in making the selection of a primary care physician in the MaineCare Mangaged Care benefit. It records member history, and tracks any actions taken on behalf of the member.

2. The second major functional area is the capitation module. This module takes the number of members enrolled to each primary care physician and calculates a payment based on the number of members. The result is a monthly capitation calculation that produces a prospective and a retrospective payment for each primary care physician. Histories of all payments are kept and are available through the application.

Purpose:
- To ensure timely enrollment of members.
- To assign recipients to primary care providers
- To improve the access to health care
- To capture and store relevant data
- To calculate capitation rates

Benefits:
- Day specific eligibility
- Automated capitation calculations
- Automated communication and work flow between DHS, Health Benefits Advisors, and Primary Care Providers

MMDSS

Impact: Changes will not be needed to the system for the HIV Demonstration, however, analysts will need to query the database to satisfy the numerous reporting requirements. MMDSS will be used to track the same quality indicators for the HIV Demonstration and non-Demonstration populations, thereby allowing easy comparison and quality monitoring between the two patient groups.

Description: MMDSS is a data warehouse with user-friendly front-end screens designed for the average computer user. The database contains approximately 100 gigabytes of data on-line, the bulk of which is five years of Medicaid claim and member eligibility information extracted from the WELFRE legacy system. Additionally, the system receives data from three other computer systems: MECAPS, MEPOPS, and Vital Statistics. All of the data is stored in a multidimensional database that efficiently

provides access to user queries analyzing inappropriate Medicaid utilization, excessive levels of care, fraud, cost analysis, etc.

Purpose:
- To integrate MaineCare related data in one system to provide users access to that data in a common environment
- To provide access to all MaineCare related data to efficiently produce data sets used for forecasting and trend analysis of enrollment, utilization, and financial components of the MaineCare program

Benefits:
- On-line access to five years of MaineCare related data
- Capability to integrate and relate data from multiple systems on one platform
- Substantial time savings with regard to data access and analysis compared with legacy system methods

MEPOPS

Impact: MEPOPS is the MMIS subsystem that processes pharmacy claims for the State. Impacts to the system will include appropriate edits to ensure MaineCare drug claims for the HIV benefit members are successfully adjudicated and paid.

Description: MEPOPS is a real time, on-line adjudication system that processes pharmacy claims for the MaineCare program. MEPOPS provides pharmacy providers with immediate notification of eligibility, drug coverage, and reimbursement rates. Financial files and remittance reporting are presented to the Maine state accounting system for check generation and cycle closing on a weekly basis. Drug Utilization Reports (DUR) are generated, enabling management to effectively control the program. Several different State departments have access to MEPOPS for reporting and research, such as the Bureau of Medical Services, Third Party Liability (TPL) profiles, DMHMR, Bureau of Health and the MaineCare Fraud Control Unit (MFCU). Claims data is fed to the decision support system (MMDSS) on a weekly basis. Additional reporting for the drug manufacturer rebate program is generated quarterly, within guidelines and updates from CMS.

Algorithm

The algorithm used by Maine to identify current or future MaineCare members who need to be included in the spending cap is outlined below and will be run quarterly. A flow chart and table regarding algorithm details is included in **Attachment IX.**

1. Sweep all service claims for the semi-annual period ending 6/30/02 for claims with an ICD9 diagnosis between 042 and 044.99.

2. Sweep all drug claims for the semi-annual period ending 6/30/02 for any drug claims where the GPI code is in the following range.

Name	FirstCode	LastCode	Class
Anti-Retrovirals	114070	121099	Anti-Retrovirals

3. For all Medicaid clients having at least one claim meeting one of the first 2 criteria, find all drug claims, and all service claim headers.

4. From the files created in step 3, find all Medicaid clients who meet one(or both) of the following criteria:

At least two service claims are identified from a physician or hospital with a diagnosis between 042 and 044.99
At least 60 days of any single anti-retroviral therapy drug (GPI codes as above) have been identified.

5. For all Medicaid clients identified in step 4, sum the costs of antiretroviral therapy plus the costs of claims which contain an HIV diagnosis (042-044.99). Calculate the cost of those claims divided by the cost of all service claims plus all drug claims. If the ratio is less than 25%, exclude the client.

[11] A description of the process whereby enrollees will smoothly transition from the demonstration to the non-demonstration Medicaid program without disruption in continuity of care, and/or vice versa. Refer to **A.2. and A.3 of section IV**.

Transitioning

All changes reported by the member during the twelve-month eligibility period must be reviewed by the Medical Assistance Eligibility Specialist to determine the effect of the change on the individual's eligibility. If the new information results in a change in the level of coverage, the Medical Assistance Specialist must:

- Assess the new information to determine if MaineCare coverage under a Categorically Needy coverage group exists, and transition eligibility to this new group without a lapse in coverage.
- If no Categorical coverage exists then determine a deductible period and deductible amount, if the change in coverage results in the individual being eligible or potentially eligible for Medically Needy coverage. In this instance, the individual will be placed in a six-month deductible period based on the effective date of the change in coverage.
- If a full benefits MaineCare member is no longer eligible for full benefits, but is eligible for the HIV benefit, the individual would be transitioned from full benefit MaineCare to the HIV benefit without a lapse of coverage, and without regard to the enrollment cap.

[12] A description of the provider network/access monitoring plan. Include any HIV/AIDS provider standards/qualifications/designations that the State currently utilizes, and expand upon the information provided in the State's in May 14 responses regarding provider network/access.

Provider Network

A third of Maine's population of 1.2 million live in the three urban areas of Portland, Lewiston, and Bangor. Each of these cities has two major hospitals and a large network of providers and social service agencies. The remaining two-thirds of the state's population live either in towns close to Portland, Lewiston and Bangor along Interstate 95, or they live in Maine's 30 rural areas. Though the state's rural areas are served by a number of community hospitals, Mainers regularly travel to the three metropolitan areas for medical and support services that are unavailable locally.

Comprehensive lists of Maine's HIV/AIDS consulting specialists, providers, service agencies and other resources are included as **Attachment IV**. Some areas of the state are clearly more represented than others. Portland, Maine's largest city in its most populous county, has both a large healthcare provider and social service base.

In the state's urban areas people receive care from Primary Care Physicians in close concert with HIV/AIDS specialists. There are not significant geographic access issues for rural residents to Primary Care Physicians. The great majority of PCP's in Maine participate in MaineCare and many are HIV providers as well. Most PCP's who provide HIV care interact regularly with their geographically closest HIV/AIDS specialist, and most patients are seen several times a year by their HIV/AIDS specialist.

Provider Participation

Provider participation and associated requirements are specified in Chapter I, sections 1.03 through sections 1.03-4 (General Administrative Policies and Procedures) of the MaineCare Benefits Manual.

[13] A detailed discussion of the cost-sharing information requested in Section **IV F 1-3**. Include any forms or information documents utilized as an attachment to the protocol document.

Premium Management

The Bureau of Family Independence currently collects premiums from members for participation in other MaineCare programs. Collection for HIV Waiver premiums will be accomplished through this existing system. BFI will notify HIV Waiver members of any monthly premium, instruct them regarding where to send payment, and educate them about the consequences of nonpayment. The existing MaineCare policy rules regarding premiums for 'Working Disabled' (MaineCare Policy, Sections 3700-06 through 3700-09) will be modified and adopted for the HIV Waiver benefit.

Changes

If the individual becomes eligible for MaineCare without a premium because of a change in income and the income change is expected to last for a full calendar month, the individual will be moved to MaineCare coverage without a premium. This change is made effective the month the change occurred as long as this change is reported within 10 days of its occurrence; otherwise, it is effective the month the change is reported. "Occurrence" is the date the change takes place.

The individual will be given a refund for any prepaid months in which s/he is subsequently moved to coverage without a fee.

Premiums

A premium payment is due for each month the individual is open for MaineCare under this benefit unless s/he is exempt from a premium as identified below.

Premiums are due on the first day of each month of coverage.

Changes in Premium Amount

If the member's income changes so that no premium is due or the amount of the premium increases or decreases, this change will be made as follows:

I. the change in income must be expected to last a full calendar month,

II. the change will be effective for the month the income changed as long as the change is reported within 10 days of it's occurrence; otherwise, the change is effective the month after the change is reported.

III. the premium amount will be changed no more than once every 6 months.

The premium amount is based on countable monthly income projected for the twelve-month eligibility period. A premium is effective the month an individual is added for coverage under this coverage group. If premiums are prepaid and the client's HIV Waiver eligibility ends, any amount overpaid will be refunded.

Premium amounts:

Income Level	* Monthly Premium
Less than 150% of Federal Poverty Level	0
Between 150% - 200% of Federal Poverty Level	$20
Between 200% - 250% of Federal Poverty Level	$40

As noted in Protocol 2, Premiums will be inflated by 5% annually, according to the following schedule:

Year	Gross Premium, Adjusted for Inflation	Actual Premium, Income level <150% Poverty	Actual Premium, Income level 150-200% Poverty	Actual Premium, Income level 200-250% Poverty
0	80	$0	$ 20.00	$ 40.00
1	84	$0	$ 21.00	$ 42.00
2	88	$0	$ 22.05	$ 44.10
3	93	$0	$ 23.15	$ 46.31
4	97	$0	$ 24.31	$ 48.63
5	102	$0	$ 25.53	$ 51.06

Exemptions from Premium Payment

An individual is exempt from a premium:

a. If countable income is less than or equal to 150% of the federal poverty level.

b. If there is good cause for premiums not paid or not paid when due because of one of the following reasons:

    1. Mail delay;

    2. Illness of the individual or their responsible relative;

    3. Unanticipated emergency beyond the control of the individual or their responsible relative.

c. During periods of retroactive coverage.

Payment of Premiums

Premiums can be paid monthly, for multiple months, or they can be paid in advance for the twelve-month review period. Payments will be credited to the earliest months of coverage first, during the current twelve month review period.

For example: A monthly premium of $20 is due during a twelve-month review period from January through December and the first payment of $220 is received on December 1st. Months one through eleven (1-11) will be credited with a premium paid. The December payment is overdue.

When a premium is not paid by the first of the month in which it is due the Department will give notice of nonpayment. There is a grace period for nonpayment of premiums. The grace period extends through the last day of the twelve-month review period.

For example: If the review period is January through December, the individual has until December 31 to pay his or her premiums for the period January to December.

If the last day of the month falls on a weekend or holiday the premium is then due on the next workday.

If eligibility under this coverage group ends prior to the close of the twelve-month review period, the grace period for premium payment extends to the last day of the month in which coverage under the HIV Waiver ends.

For example, an individual granted October, 2002 has a review date of September, 2003 but his coverage is changed to MaineCare without a premium for December. The grace period for payment of premiums for October and November is November 30.

If eligibility under this coverage group is continued pending a fair hearing and a premium is due, the grace period is the last day of the month for which coverage is provided.

For example, the premium for the month of July is due July 1st. The grace period extends to July 31st.

Nonpayment of Premiums

At the beginning of month twelve of the review period, notification will be given if any premiums for the review period have not been paid when due. The individual will also be notified of the penalty incurred because of the nonpayment.

At the twelve-month review a determination will be made as to whether there are any overdue premiums. If so, coverage under the HIV Waiver benefit will end unless there is "good cause" for nonpayment. Coverage cannot begin again until any unpaid premiums are paid. If an individual's MaineCare eligibility ends due to non-payment of premiums, re-enrollment in the HIV Waiver is subject to availability of a slot, under the enrollment limit.

Administrative Hearings

Coverage by the HIV Waiver benefit continues pending a hearing decision if an administrative hearing is requested, even if the individual is not paying premiums that are due. If the individual was responsible for paying a premium prior to the proposed negative action, this premium will continue to be due.

If the individual is upheld at the fair hearing and they have overpaid any premiums s/he will be issued a refund.

Co-pay Management

The MaineCare enrollment cards will inform providers to call the Voice Response System to determine co-payment. In addition, the MEPOPS system will alert pharmacies of required medication copayments. Collection of copayments for prescriptions and medical services is the responsibility of the pharmacy or medical provider. Maine Bureau of Medical Services assumes no responsibility for a provider's failure to collect co-payments.

[14] Include as an attachment to the protocol document the evaluation design report as discussed in **Attachment B, number 1**.

Evaluation Design

Maine Health Research Institute (MHRI) has developed an evaluation plan and set of indicators to be coordinated with DHS. The five hypotheses around which the HIV Waiver proposal was built are:

1. Early and Continuous Treatment with HAART therapy will increase life expectancy, decrease disability, and decrease rate of movement to AIDS.
2. Members will comply with medical treatment and drug use at a high rate.
3. Memeber satisfaction with quality of life will increase.
4. Close case management and disease state management will increase provider and patient compliance with treatment.
5. Costs of care will increase at a rate no more than general medical inflation rates.

Systems developed to support program evaluation will be integrated with the existing MaineCare systems including MEPOPS and MMDSS, and with new systems as they are developed and used to support the Waiver benefit operations, care management, and quality management. To the extent necessary, measures of member health status, member satisfaction, provider satisfaction, and other information will be added to existing information systems to create a highly integrated administrative and clinical information system.

The following indicators will be monitored with frequencies as noted:

- Enrollment, Stratified by Disease and HIV Waiver status (MaineCare and Expansion) (Quarterly)
- Size of the waiting list (Quarterly)
- Costs (Quarterly)
  - Cost PMPM, stratified by category of service
  - Actual vs. Budget
- Measures of Care Process, stratified by disease state, Waiver status (Quarterly), medical care provider and case manager
  - Physician visits
  - HAART therapy
  - Average number of drugs PMPM
  - Pct patients on no, one, two, three, four, etc. drugs
  - Laboratory Monitoring
  - Hospitalization Rates
  - Adherence to Therapy
- Outcome (semi-annually)
  - Death Rates
  - Disease State Progression Rates
  - Disenrollment

[15] Include the State's method to ensure that the latest in HIV treatment guidelines will be made available to providers in the State and the extent to which HIV expert/consultation services will made available to providers.

Provider Outreach and Education

Outreach to providers will be done primarily through the Bureau of Medical Services using a number of methods, including:

- Primary physicians who have enrollees in the benefit will be sent a packet of information that will include the newest treatment guidelines for both antiretroviral therapy and opportunistic infection management. Information will be regularly updated through mailings to all physicians with patients enrolled in the benefit.

- At least annual educational sessions on the primary care management of HIV will be held regionally throughout the state, with particular focus on requested topics and case studies that demonstrate the decision-making process in treating HIV.

- All physicians with patients in the benefit will have timely access to a clinical HIV expert consultant.

[16] Please describe in more detail the composition and operations of the Clinical Advisory Committee (discussed in the May 14, 1999 responses to HCFA questions), including the background/expertise of committee members; the mechanism for the committee's communication with provider and client communities, including the provision of relevant clinical information to Medicaid providers in Maine, and the committee's overall role in the Medicaid program in Maine, particularly with respect to monitoring quality of care.

The Advisory Committees

The Bureau of Medical Services Physician Advisory Committee will act as the Maine HIV/AIDS 1115 Demonstration benefit advisory committee. The Bureau of Medical Services Medical Director, a board certified infectious disease and internal medicine Doctor of Osteopathy, will serve on the Physician Advisory Committee. Other committee members include Doctors of Medicine, Osteopathy, and Pharmacy, a past president of the Maine Chapter of the American Academy of Pediatrics, the current president of the Maine Chapter of Physicians, and infectious disease experts and providers with a background in HIV and AIDS management.

Committee Roles:

The Physician Advisory Committee will provide clinical support to the benefit with ongoing input from HIV/AIDS specialists. It will monitor the standards of treatment and update them as needed. It will coordinate with the Drug Utilization Review Committee as appropriate.

The Drug Utilization Review Committee will coordinate with the Physician Advisory Committee to supply oversight on pharmaceuticals. Coordination between the Physician Advisory Committee, the Drug Utilization Review Committee, HIV advocates, and the community will be performed by a Health Program Coordinator employed by the state Bureau of Medical Services. The Program Coordinator will ensure effective communication between both committees and the BMS Medical Director. In addition, the coordinator will maintain contact with the BOH Committee on AIDS.

[17] A description of the State's plan to monitor demonstration participants' adherence to treatment regimen[s]. Include details about case management and other services that will be available to assist and support patient adherence. Also include further details about the "system pharmacy edits" [mentioned in the State's October 21, 1999, responses to HCFA questions] that will be used to monitor optimal drug treatment / management and trigger appropriate intervention in the event there are problems with treatment adherence.

This is a two-part protocol: 1. Case Management; 2. Pharmacy Edits.

1. Case Management

Discussion concerning the Department of Human Service's proposal for assessment and coordination of agencies that provide assistance to HIV/AIDS affected clients appears in Protocol #3. DHS views the newly approved Maine HIV benefit as an opportunity to address the lack of integration of HIV prevention and care services to HIV-positive people through focused collaboration between the Bureau of Medical Services, and the Bureau of Health.

BMS and BOH have entered into an agreement to work together to assure the success of the proposal, whose goals are to: maximize utilization of the case management capacity already existing in community agencies, identify the points where various agencies interact, and address the entire continuum of care (beginning to end stage).

2. System Pharmacy Edits

We have in place a system of pharmacy edits (**Attachment VII**), and will use the State's data system to follow NIH guidelines, as previously referenced. Pharmacy edits will be constantly modified—they will be dynamic, not static edits.

ATTACHMENTS

I. State of Maine / MCBM Chapter 1

II. Waiting List Notification letter template

III. NIH Treatment Guidelines

IV. HIV / AIDS Resource Lists

V. Informational Materials

VI. Examples of Relevant Forms

VII. Waiver Member Informed Consent Form

VIII. Draft Pharmacy Edits and QA

IX. Algorithm Flow Chart and Table

Attachment I

CHAPTER 1 of the MAINECARE BENEFITS MANUAL

Attachment II

WAITING LIST NOTIFICATION LETTER TEMPLATE

Attachment III

NIH TREATMENT GUIDELINES

Attachment IV

HIV / AIDS RESOURCE LISTS

Attachment V.

INFORMATIONAL MATERIALS

Attachment VI.

EXAMPLES OF RELEVANT FORMS

Attachment VII.

HIV BENEFIT MEMBER INFORMED CONSENT FORM

Attachment VIII.

DRAFT PHARMACY EDITS AND QA

***Attachment IX*.**

Algorithm Flow Chart and Table